TASC

Technical Assistance and Services Center

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Topic: Critical Access Hospitals and Access to Capital

On March 2, 2000, Charles Ervin of AMI Capital, Inc., Eric Shell of Northland Health Group, and Jerry Coopey from the Federal Office of Rural Health Policy, met with representatives of the Department of Housing and Urban Development (HUD), HRSA and Division of Facilities and Loans (DFL) to discuss the Medicare Rural Hospital Flexibility Program, the need of Critical Access Hospitals (CAHs) to access capital, and the applicability of the HUD 242 program to CAHs. This TASC Briefing provides an overview of these topics.

Rural Market Demand for Capital

Many of today's rural hospitals were primarily financed through the Hill-Burton program and supplemented with the early cost-based Medicare payment system in which capital costs were allowable. However, rural hospitals were adversely affected in 1984 when Medicare began paying all hospital inpatient services on a prospective payment basis, with rural hospitals receiving up to 40% less than their urban counterparts. Beginning in 1991, Medicare paid capital costs on a phased-in prospective payment basis. The result has been that since 1984, rural hospitals have been too unprofitable and capital pass-through too tenuous for facilities to be substantially upgraded. Thus, many rural hospitals have aging physical plants resulting in increased survey deficiencies and significant out-migration to newer, urban facilities.

HUD 242 Program

The current HUD 242 program facilitates affordable financing for licensed hospitals and acute care providers by protecting investors against loss of principal. They do this by guaranteeing the payment of principal and interest, should default occur. With HUD's mortgage insurance, hospitals are able to have their debt financed as an investment grade (either AA or AAA), which provides the lowest borrowing rates available in the capital markets. Without this guarantee, hospital debt is often categorized as "Junk" grade with associated high financing costs. Proceeds can be used to finance the construction or rehabilitation of acute care hospitals including major moveable equipment.

Other important features of the HUD 242 program include:

- 25-year fixed rate financing;
- Loan are limited by either 90% or replacement cost, including land and major moveable equipment contributed at market value; and
- Competitive interest rates based upon 85 basis points spread over the 25-year Treasury bond.

The applicant must furnish detailed information about its proposed hospital construction or rehabilitation to DFL, which decides whether the proposal is feasible. If feasible, the candidate must engage an outside accounting firm to perform a formal financial feasibility study. As currently implemented, the required financial feasibility study is extensive (and expensive). HUD officials have indicated they might be willing to accept an abbreviated (less expensive) study for smaller hospital loans. A Certificate of Need (CON) from the appropriate state agency, or alternative study if the hospital is in a non-CON state, is also required. The applicant then submits a formal application with the feasibility study through the local HUD office where final decision is made.

Applicability to CAHs

Historically, the HUD 242 program has not been available to small rural hospitals. The primary reason is that hospital candidates are required to prove with historical financial statements and five-year financial projections that certain profitability and debt service ratios had been maintained and will continue to be met. The thresholds for these ratios have often eliminated the opportunity for rural hospitals to participate in the program.

At the March 2 meeting, Ervin and Shell were able to demonstrate that CAH designation could significantly alter the financial performance of small hospitals by stabilizing a significant portion of revenue (through cost-based reimbursement), as well as improving financial performance. HUD representatives seemed willing to place substantially more importance on projected financial performance as a CAH than on historical performance. This might provide an opportunity for CAHs to access this program.

HUD representatives requests that the financial consultants work with a few CAHs interested in major capital improvements by helping them prepare for the pre-application process. DFL and HUD have indicated that they would work with these hospitals in an expedited manor to create the systems necessary to accommodate the CAH program. They are currently working with three Arkansas hospitals interested in accessing major capital and are interested in discussing this with other potential facilities. For additional information, contact Charles Ervin (770-777-2929), Eric Shell (207-767-7500) or TASC (218-720-0700).